

FIG. 1

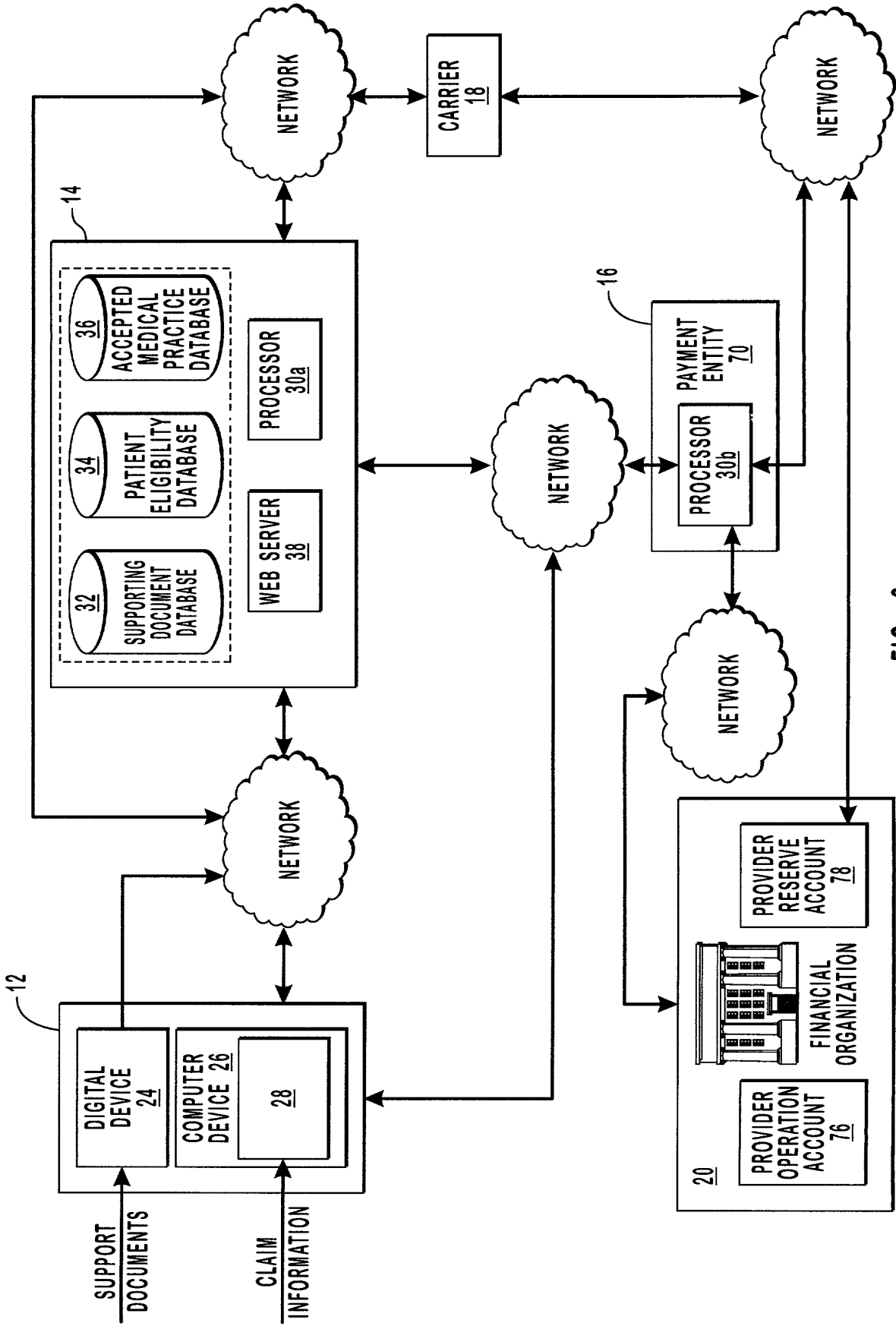


FIG. 2

28a

## Health Care Claims Form

Plan I D	
Insured's I D	
Paitent's date of birth	- mm/dd/yy
Provider I D	

FIG. 3

28b

## Health Care Claims Form

Plan ID : 1234

Insured : Doe, John 541XXXXX

Patient : 01, Jane

Provider: MISCELLANEOUS PROVIDERS

Please enter the Patient Dependent Number from above from above:										56
Last Name, First, Middle Initial, I.D.										
Referring Physician										
Service Provider										
Diagnosis or Nature of Illness or Injury.										
52		52								
52		52								

Dates of Service		Place	Type	Procedure, Service or Supplies			Diagnosis No			\$Charges	60
From	To	Svc	Svc	CPT	Modifier						
					54						

Patient's Account		Accept Assign?	Total Charge	62
		Yes <input type="radio"/> No <input type="radio"/>	Amount Paid	58
			Balance Due	64

FIG. 4

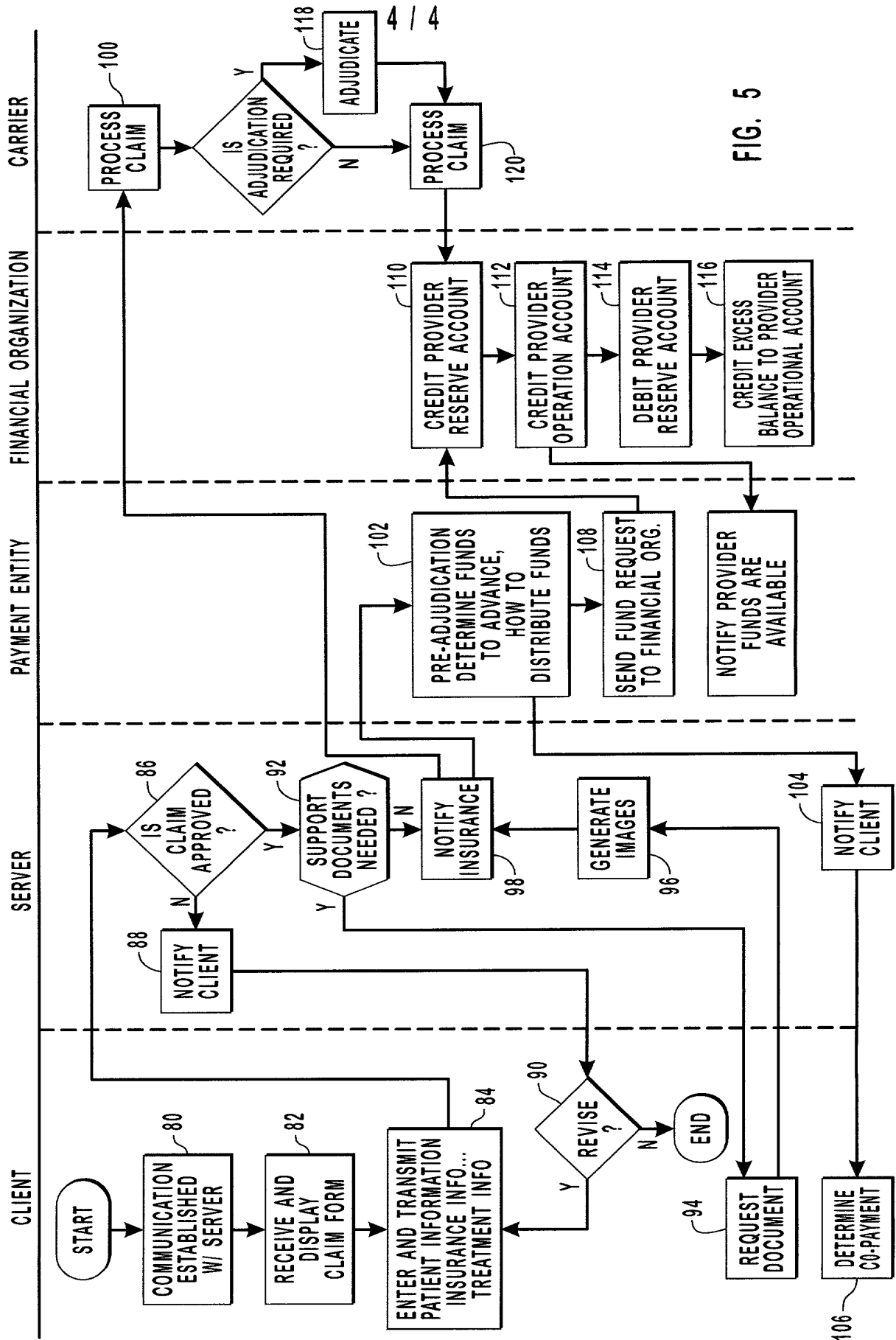


FIG. 5